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This is to certify that the thesis presented to us by Kelly M. Phipps

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of the requirements for the degree of Master of Arts has been

examined and is acceptable in both scholarship and literary quality.

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A Place for My Self:

Issues of Space in Dance/Movement Therapy with Women in a Homeless Shelter

Thesis

Presented to

the Faculty of the Graduate School

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Master of Arts

by

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Abstract

As homelessness in the United States continues to rise, research into the specific needs for treatment of this population is increasing. Both personal and social factors contribute to homelessness as well as different reasons due to gender (North and Smith,1993). Loss of personal, interpersonal and societal space occur as a result of homelessness. This loss of spatial boundaries can lead to the inability of an individual to overcome his homeless condition.

This study was undertaken in an effort to demonstrate a relationship between issues of space among the homeless and dance/movement therapy concepts to produce a program that would be beneficial to women living in a homeless shelter. As literature pertaining to dance/movement therapy with the homeless is extremely limited, the study consisted of a literature review of women and homelessness, space and dance/movement therapy with relavent populations. In addition, clinical application of dance/movement therapy to this population is given and illustrated with short case vignettes.

Findings showed that dance/movement therapy concepts of space were applicable to the traumas such as physical and sexual abuse, drug addiction and victimization experience by homeless women. The non-verbal nature and use of the body in dance/movement therapy is able to address these issues at the site of their experience.

The conclusion is that dance/movement therapy, especially work geared toward personal space and boundary development, can play a beneficial role in helping women escape patterns of homelessness.

DEDICATION

This thesis is dedicated to the women at the shelter who are working hard to change their lives.

> We learn to listen to our own voices
> if we are listening at the same time
> to other women--- whose stories, for
> all our differences, turn out, if we
> listen well, to be our stories also.
>
> --Barbara Deming

> Let us find our place among them.
> Let us do what we can.
>
> --David Read Johnson

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To my mother, who has always encouraged my dreams and who recognized my love for dance.

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To Dennis, for his love, belief and tenderness. Thank you for all that you give and bring to my life.

To the people, places and events that have shaped my life and brought me now to the brink of this great adventure. I have found my tribe.

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CHAPTER I. INTRODUCTION

Homelessness is a significant and growing problem in the U.S. today. Once almost exclusively alcoholic older men, the faces of today's homeless are those of not only men, but women, children, the elderly and the mentally ill. Homelessness in the United States dates back to the 1790's with peaks during the Great Depression and steadily rising since the 1970's (Rossi, 1990). Existing in good times as well as bad, homelessness can no longer be viewed as a temporary phenomenon that appears only in periods of economic depression or social malaise (Coston,1989).

Webster's dictionary (1986) defines "homeless" simply as having no home or permanent place of residence." To be "without a home" carries great personal and societal significance. It must be realized that environment, more specifically "personal place" is a key determinant in an individual's definition of one's self. People and places are not independent parts of living. "Personal place" describes one's group membership and significantly contributes to one's definition of his/her sense of

identity, feelings of self-worth and self-efficacy (Rivlin,1986; Buckner, Bassuk and Zima,1993).

Space and its use can be a metaphor for a variety of issues. The experience of losing one's physical space and societal status, a "place" in society, is often compounded by subsequent, previous or ongoing breeches of personal boundaries due to physical, sexual and/or substance abuse. Compromised in space, the individual has difficulty defining herself on a personal, interpersonal and societal level. Without a "place" in society, the homeless become outsiders to themselves as well as to their community. At the Eliza Shirley House, a shelter for homeless women in Philadelphia, the development of effective short-term treatment for the diverse needs of this population is mandatory.

This thesis proposes to study and present the treatment issues of homeless women in terms of space, which is operationally defined as an individual's personal, physical and societal place. The present study seeks to determine if the compromisation of personal, societal and residential space has a relationship to dance/movement therapy theoretical concepts. Through a review of literature, a synthesis of a dance/movement therapy theoretical framework will be created from which to address and treat the immediate psychological needs of these women. This design

does not use human subjects but refers to the author's clinical setting and group activities. The objective of this thesis is to demonstrate the unique contribution of dance/movement therapy for identifying and addressing the needs of women in a homeless shelter and that this will be supported by the researched literature.

Dance/Movemement therapy is a form of psychotherapy in which the therapist utilizes movement interaction as the primary means for accomplishing therapeutic goals (Schmais,1974). It addresses the individual at his level of functioning, both verbally and nonverbally. The exploration and use of one's kinesphere or personal space is emphasized as well as relating to others on a body level. It addresses the personal internal/external feelings, interpersonal dynamics and societal or group relations. In this manner, one is able to address such issues using the same mode in which they naturally occur and are experienced.

Space in its most general sense can be defined as an expanse extending in all directions, in which material objects such as people and buildings are located (Barnhart & Stein,1968).

Laban's original theory of effort/shape described the way and means by which an individual interacts with his environment. The quality of the flow of tension, either

bound or free and the mover's attitude towards the motion factors to describe the effort an individual makes: body weight by being either light or forceful, the quality of sustaining or quickening time and spatial focus or attention being either direct or indirect. Shape is determined by how a person interacts with the environment. This can be through molding one's body to objects, adjusting to internal stimulus or linking the body to a place in space (Dell,1977). Impairment results when an individual is unable to utilize all of these elements.

North's work (1972) addresses pathology related to effort impairment/exaggeration. In reference to the use of the space effort, excessive multi-focused or indirect use of space can result in "exaggerated deviating and avoidant behavior" (p.235). On the other end, exaggerated use of direct focused use of space can produce "narrow-minded or obsessional points of view" (p.235).

The concept of spatial intent (Bartenieff,1980) is the preparation and initiation in a movement sequence that determines the whole course of a sequence and the quality of its function and/or expressiveness. The inability to organize and execute spatial intention decreases an individual's ability to communicate and achieve her goal.

The works of Scheflen (1972) and Hall (1968) explore social communication through spatial usage and includes use of space and distance, territoriality, seating arrangements and behaviors of touch. They discuss space as a medium for transmitting specific cultural messages and its use to establish and maintain social order.

Theoretical research in the study of the use of space in dance/movement therapy has been limited. Writings have included work in correlating verbal/spatial behavior (Curtis,1980), spatial behavior of a manic (Evans,1988) as well as developmental needs (Avstreih,1981) and working alliances (Bovard-Taylor and Draganosky,1979).

As for dance/movement therapy with the homeless, Judith Ginzberg's work (1991) is the only writing to date. In it, she identifies and describes the population and outlines the establishment of dance/movement therapy in two shelters. Initial goals include establishing trust, reducing tension, enhancing self-esteem, facilitating self-expression and creativity, and promoting group interaction and understanding among homeless men. Additional writings (Leventhal and Chang,1991; Scarth,1992; Perlmutter,1991; Milliken,1990; Fisher,1990; Bartky,1980; Reiland,1990) discuss the effective application of dance/movement therapy to battered woman and substance abusing populations.

The thesis will include general descriptions of group dance/movement therapy at a local homeless shelter for women in Philadelphia. Group members are all survivors of some type of abuse which could be physical, sexual or substance abuse. They are enrolled in dance/movement therapy on a volunteer basis and must be willing to participate in group activities. They must be referred for dance/movement therapy by full-time clinical staff who are mental health professionals. Individual women will not be described directly nor by name. Descriptions of clinical work will be included for illustrative purposes only.

The format will consist of a literature review that will be divided into three sections. The first section will address homeless women in terms of specific, related areas/issues. Under this heading will be a review of the psychological needs of homeless women and the current available treatment. Issues of victimization, domestic violence, sexual abuse and drug and alcohol addiction as contributors to homelessness will be discussed as well as their psychologically traumatic implications. The trauma of homelessness in and of itself will be identified as an impairing factor in the healthy use of space for good mental health.

The second section will review literature concerning the concept of space on personal, interpersonal and societal levels. Definitions and discussion of normal development of usage of space will be provided. Pathology resulting from the impairment or dysfunction of the use of space in regards to homelessness will also be discussed.

The third section will review basic tenets of dance/movement therapy. It will also include a section reviewing specific dance/movement therapy literature concerning treatment issues found in the homeless population such as domestic abuse and drug addiction. When possible, concepts concerning space and its use for treatment of these populations will be discussed.

An outline of the implemented program with clinical examples will be given of how dance/movement therapy deals directly with these issues of space and mobilization.

The discussion section will seek to integrate the previous sections in looking at homelessness as a state of compromised space that impairs the individual's ability to overcome her current living status and move forward with her life.

A final section will provide a summary of the material covered and provisions for further investigation, including ideas for quasi-experimental research and/or outcome study.

CHAPTER II. REVIEW OF THE LITERATURE

PART 1. WOMEN AND HOMELESSNESS

Homelessness has always existed in the United States, increasing in times of economic stress and declining in periods of prosperity (Monkkonen, 1984). But not since the Great Depression has there been as many homeless in the United States. Previously, homelessness referred to alcoholic older men who lived in flop houses and worked intermittently. Today's homeless are younger, more likely to be minority group members, suffer from greater poverty and have access to poorer sleeping quarters (Rossi,1990). Rossi also found substantial increases in the number of women and families now living on the streets. Whereas women were only 3% of the homeless population in the 50's and 60's, they now swell the ranks of homelessness as 20-50% of today's population and is its fastest growing segment (Waxman and Reyes,1987; U.S.Conference of Mayors,1991).

The rise in the number people at or below the poverty level, decreased availability of low income housing and the growing scarcity of government support programs are the

reasons cited for this growing homeless faction (Weitzman, Knickman and Shinn, 1990). A growing trend in society seems to be to fix the blame on the individual for his condition. Where that may be true in some cases, it does not hold true for all. Blaming the individual fails to acknowledge the economic and societal influences behind homelessness. A growing segment of the homeless population are those called the situational homeless-- homelessness precipitated by immediate economic problems that occur without major individual dysfunction such as psychological impairment or drug and alcohol abuse. This group along with the chronic mentally ill, alcoholic and street people constitute today's homeless population (Fischer and Breakey,1986).

Variables Influencing Homelessness amongst Women

Whereas the different populations require different services, research also shows that men and women become homeless and experience homelessness differently. Whereas the most common reasons for men to experience homelessness are alcoholism, unemployment and jail release, women are on the streets more often due to eviction or domestic violence (Hagen,1987). Multi-causal factors leading to situational homelessness for women are the feminization of poverty, scarcity of affordable housing, unemployment, teenage

pregnancy, domestic violence and family disruption (Sullivan and Danrosch,1987).

Financial Difficulties. Many homeless are victims of urban renewal, gentrification and a deinstitutionalization process that left them without care arrangements (Slavinsky and Cousins,1982). Amongst women, gender and work structures can combine to produce homelessness (Merves,1992, p.232). A traditional economic and social system that defines women first and foremost as wives and mothers leaves the working woman vulnerable to situational homelessness because of inequality in pay, little change in life-cycle earnings and lack of acknowledgement of unemployment amongst women. Discrimination against female-headed house-holds and families receiving welfare makes it difficult to find decent housing at an affordable price. Economic vulnerability coupled with poor housing pose significant risk for becoming homeless.

Social Stereotyping. Whereas the economy can be blamed for the prevalence of homeless men, women are more often blamed personally for failures as a marriage partners or parents (Merves,1992). Merves states that stricter guidelines of gender roles increase the likelihood of homeless women being seen as social outcasts and generalized as bag ladies, prostitutes and bad mothers . The popular

stereotype of the "bag lady" has greatly contributed to the misunderstanding of the plight of homeless women and the failure to address this situation. The characterization of these women as psychological misfits who refuse assistance reduced them to quaint caricatures:

> Homeless women are not always immediately identifiable, but certain tell-tale habit patterns are usually visible. Some women wear garments that are ragged and torn while others, regardless of the weather, wear layers of clothing of unmatched colors, textures and designs. Many of them have the distinguishing habit of packing all of their belongings in grocery, garbage and/or shopping bags and either pushing or carrying those bags with them along the streets (Coston,1989).

Factors such as vulnerability to crime, street hazards and the elements are often left out of such definitions. The population of homeless women is diverse including all ages, races, ethnic groups and social backgrounds. Some hold professional degrees or were otherwise employed prior to becoming homeless.

Dependent Children. Children are an added factor to the situation of homeless women serving as a paradoxical strength and stressor. Homeless mothers with young children tend to be younger in age, more likely to be a minority and dependent on welfare programs (North and Smith,1993). The perpetual concern of losing custody of the children is

compounded by the risk of exposing children to the drug and alcohol abuse, mental illness and behavioral problems seen in shelters (Milburn and D'Ercole,1991). D'Ercole and Stuening (1990) report findings that women who are without their children experience a greater loss of self-esteem, more role strain, and greater vulnerability for involvement in problem behaviors than when they are living with their children. This author has observed in clinical work that issues of being reunited with children and being able to provide for them is a sensitive topic that weighs heavily on the women's minds.

Victimization. The degree of victimization amongst homeless women is significant (Bassuk,1987; D'Ercole and Struening,1990; Merves,1992; Somers,1992; Milburn and D'Ercole,1991; Hagen and Ivanoff,1988; Gold,1986; Peterson and Sigelman,1983; Farge,1989; Brown,1993; Goodman,Saxe and Harvey,1991). Breton and Bunston(1992) reported 75% of women in a shelter study related physical and/or sexual assault at some point in their life. Child abuse, incest, rape and battery were all listed. The majority of these were repeated incidences. The popular image is that an abused woman will continue to become involved in abusive relationships. Research findings indicate that in the majority of cases, the abuse occurred before the women became homeless (Breton

and Bunston,1992). The conscious leaving the situation despite the subsequent entrance into homelessness demonstrates competency and coping skills on the part of the individual.

Victimization may disrupt important social bonds and impair one's ability to form positive interpersonal networks (Van der Kolk,1987). The internalization of their victimization and profound disillusionment can result in pervasive feelings of self-blame and punishment, not feeling like a human being, disappointment with life and questioning its meaning, and resentment toward other social groups whom some agencies consider more worthy of services (Merves,1992) Other long-term effects of victimization include emotional numbness, maladaptive passivity, helplessness, apathy (Peterson and Seligman,1983), low self-esteem, guilt feelings, and interpersonal difficulties characterized by feelings of isolation and difficulty trusting others (Gold,1986). Believing that their situation is beyond their control, extreme hopelessness, powerlessness and despair result. Disappointment with societal institutions such as family and work structures stem from unanticipated alienation, pain, and suffering. The painful lesson that there are no guarantees for a good life despite hard work is discouraging. Further victimization results as these women

do not receive the necessary services due to their invisibility as a needy population and because they pose less perceived physical threat than do homeless men to society.

Domestic violence. The occurance of homelessness precipitated by domestic violence has often been left out of research on homeless women. Domestic violence occurs among all classes and races with males being the most common perpetrators. Once it occurs, it is likely to continue and increase in intensity and frequency. It is often a multi-generational phenomena with an estimate of 75% of battered women having been raised in an abusive household. Both abusers and victims are found to have low self-esteem and poor communication skills. There is pressure to maintain an intact family at the expense of their own well-being. Often the abuser will isolate the victim from developing social support systems such as friends or family which would defray some of the stressors. Many victims present symptoms such as anxiety, depression, gastrointestinal complaints, back pain, headaches and other somatic concerns (Hilberman and Munson,1978). These are often cover-ups of the abuse as well as manifestations of the distress. Besides feelings of low self-worth, female victims are often powerless to be self-sufficient without job training, money management

skills and other practical skills that would allow them to be independent. The crisis generated by domestic violence compounded by wage discrimination in the labor force as well as the decline in public assistance and affordable housing has produced a population of women and children who must either remain in life-threatening circumstances or become homeless (Somers,1992). Besides the numerous legal proceedings and support needed for a victim to leave her abuser, long-term group and individual counseling is recommended to develop the skills and self-esteem necessary for her to not enter another battering relationship.

In some instances, the woman is the perpetrator of violence against her spouse, children or parents. Inability to cope with intense rage and anger and limited options for expression can lead to both verbal and physical abusiveness. In such cases, taking the woman out of the situation may be the best solution in order to deal with her rage.

Trauma of Homelessnes. Homelessness itself can be viewed as a major mental health stressor (Bassuk,1987; Milburn and D'Ercole,1991; Koegel and Burnam,1992; Goodman,Saxe and Harvey,1991). Emotional problems such as post-traumatic stress disorder (PTSD), feelings of alienation and learned helplessness can exacerbate trauma symptoms (Goodman, Saxe and Harvey,1991). Psychological

trauma is a set of responses to extraordinary, emotionally overwhelming and personally uncontrollable life events such as rape or prolonged trauma such as battering (Van der Kolk,1987). Trauma is not to be confused with mental illness although trauma can exacerbate or make an individual vulnerable to mental illness (Buckner,Bassuk and Zima,1993). It is not possible to detangle mental health issues from homelessness but addressing the needs of the severely mentally ill homeless is beyond the scope of this study. Social disaffiliation comes from Bowlby's theory (1980) that intimate and long-lasting attachments, feelings of safety and connection are necessary for a child to have emotional security and the ability to develop self-reliance, autonomy and self-esteem. Ruptures in interpersonal trust creates a loss of sense of control (Goodman,Saxe and Harvey,1991). With possible psychological vulnerabilities, the stress of poverty, violence and profound deprivation has lasting effects on a person's development and self-esteem. Poverty erodes an individual's self-esteem and confidence and creates a feeling of despair and alienation. This coupled with the breakdown of family structure and values can create what is referred to as a "tangle of pathology" (Bassuk, 1987).

Individuals who lack essential early nurturance from a mothering figure, have been abused and lived in chaos during formative years or who lack positive role models often manifest profound deprivation by developing personality disorders later in life. Bassuk's (1987) data indicates that more than two-thirds of homeless mothers demonstrate behavioral disorders. Unable to establish themselves as autonomous adults, they have difficulty forming and maintaining stable relationships, have poor or nonexistent work histories, have been unable to establish stable homes even when housing was provided and most importantly, have extreme difficulty parenting. Lack of appropriate support structures or the ability to utilize them make these women overly dependent on their relationships with their children as their sole support for their emotional needs. Otherwise, many of the women report having no emotionally supportive relationships.

Substance Abuse. Drug and alcohol abuse is the leading health problem among the homeless(Fischer and Breakey,1991; McCarty,Argeriou,Huebner and Lubran,1991; Drake,Osher and Wallach,1991). As many as 40-55% of the homeless population abuse drugs, alcohol or a combination of the two(Fischer and Breakey,1991). While the percentages of drug and alcohol abuse are higher for men than for women,

studies seem to link substance abuse to mental illness more often with women than with men. This could be the result of gender biased diagnoses but is still a significant treatment issue. Substance abuse decreases alertness and judgment and increases the risk of victimization. Increased incidences of head injuries, fights and prostitution also contribute (North,Smith and Spitznagel,1994). The women can also be aggressive themselves demonstrating antisocial behaviors and impulsivity due to the frustrations and stress of homelessness. Substance abusers tend to have histories of a difficult childhood, abuse and violence at an early age. Growing up in dangerous neighborhoods or dysfunctional families have exposed them to patterns of abuse that are carried over into adulthood. These women will often chose mates who are substance abusive, antisocial or violent (North,Smith and Spitznagel,1994).

Substance abuse also interferes with employment histories and taxes social resources (Buckner,Bassuk and Zima,1993). While many of the women do not feel that drug and alcohol abuse affects their relationships with their children, evidence of children being taken from the addicted mothers by social service agencies refute this (Shinn,Knickman and Weitzman,1991). Homeless individuals who are diagnosed with both substance abuse and a mental

disorder exhibit greater isolation, mistrust of others, resistance in seeking care, compounds homeless status and exacerbated psychosis (Blankertz and White,1990; Buckner, Bassuk and Zima,1993).

Research of drug and alcohol abuse amongst the homeless is problematic. As statistics link substance abuse to homelessness, societal sympathy for the homeless decreases, labeling them "undeserving." The pathologicalizing of homelessness on the basis of drug and alcohol abuse and mental illness fails to acknowledge the overwhelming social, political and economic problems contributing to the homeless condition (Fischer and Breakey,1991). The use of substances complicates the individuals situation while the situation serves to exacerbate symptoms of addiction (McCarty, Argeriou, Huebner and Lubran,1991). While substance abuse is the leading individual factor contributing to homelessness, the stress of homelessness can contribute to increased substance usage.

Treatment Needs

Food and shelter are immediate needs. After these basic needs are met, intensive, relational services such as crisis counseling, long-term counseling, alcohol treatment, transitional-supportive living environments and case

management are needed to make an impactive long-range difference in the life of a displaced person (Hagen and Ivanoff,1988). Clinical treatment goals including teaching individuals to protect themselves from further trauma and how to cope with existing trauma. Promotion and nurturance of social support development that will serve as a buffer is also a goal (North and Smith,1992).

Koegel and Burnam's (1992) research links prevalence of mental disorders such as antisocial personality disorder and major depression to the necessary lifestyle changes for street survival. Criteria such as disturbed sleeping and eating patterns considered indicative of major depression can be the result of having no food and fear for personal safety while sleeping on the streets. In certain diagnoses, mental disorders may be overdiagnosed because methods of ascertainment are insensitive to the fact that symptoms associated with pathology in general populations may also be inadvertant consequences of the homeless condition. Individuals must be evaluated in the context in which they live (Fischer and Breakey,1991; Koegel and Burnam,1992; Brown,1993).

Environmental conditions greatly contribute to the successful rehabilitation of substance abusers (McCarty, Argeriou,Huebner and Lubran,1991). Shelters such as the one

in this project are "dry houses" in which there is no substance usage allowed. Urine screenings, curfews and 90 day evictions serve to enforce this rule. Such environments, while supportive of the recovering addict, are undermined by the location of many shelters in drug-invested, violent neighborhoods. Poor receptivity of these facilities by the more affluent communities is conducive to perpetuating the feeling that the homeless are fringe undesirables.

Treatment objectives in working with homeless substance abusers includes abstinence and increasing residential stability, personal health, and employment capacity/status. Such goals demand global changes in behavior. Daily ritual, sustained responsibility and credible role models of positive life change can aid in recovery (Stevens, Erickson, Tent and Chong,1993). Skill-building, group identity formation, self-esteem enhancement with focus on an sober life-style are also important (Drake,Osher and Wallach,1991).

A strong sense of self, versatility and creativity are essential for clinicians. Developing a trustworthy reputation among the population, realism about material resources available, attention to their hierarchy of needs and providing opportunities for social interaction can aid to the success of the therapeutic encounters. Services are

needed to reach out to those who are apathetic, resigned and without hope in their own places of congregation. Psychotherapy for this population is generally directive, pragmatic, and focused on solving immediate problems. Acceptance of their need for treatment, development and support of a sense of empowerment, and the understanding of the importance of a stable environment is highlighted. More introspective approaches extending over a period of time will be necessary (Breakey,1991).

Conclusion

Social disaffiliation, distrust of authority, disenchantment with mental health service providers and the multiplicity of their needs make the homeless a difficult group to serve. In order to encourage the homeless to seek needed assistance, the social stigma and bias attached to homelessness must be honestly addressed by service providers. Acknowledgement of the tremendous strengths of these individuals to face such adversity is essential. Such recognition focuses on strengths to build on in therapy. Beliefs such that homelessness is the chosen way of life cruelly limits their choices or labels the homeless as too lazy or ignorant to take care of their own needs. Internalization of such stereotypes can cause a homeless

woman to believe that such statements are true and influences her choice of coping method (D'Ercole and Milburn,1991). The belief that homelessness is a chosen "lifestyle" perpetuates its acceptance by the public of the destructive elements of our social system that contributes to homelessness (Farge,1989).

PART TWO. SPACE

In the broadest sense, space is a boundless three-dimensional extent in which objects and events occur and have relative position and direction. Space determines how individuals engage their environment, establishing how they "fit in" to their surroundings. It is man's channel for perceiving and responding to the world (Maletic,1987). Use of space contributes to the development of social interactive boundaries as well as utilized by human beings to interact with the environment in order to have needs met directly or indirectly by external elements. For the purposes of this study, space will be discuss in terms of a continuum. This ranges from the experience of inner/outer space of the body to the effects of development on the experience of space. Space on a social level will look at a variety of ways it is used in maintaining control and order on a societal level. The ramifications to the homeless population will also be discussed.

The Body in Space

Space is experienced kinaesthetically through physical, olfactory, ocular/visual, auditory and gravitational sensation. In movement terminology, personal space is

described relative to the body. Bartenieff (1980) describes the physical body as a three dimensional construct, with the capacity to lengthen, deepen and widen in space. Length, depth and width are respectively labeled the vertical, sagittal and horizontal planes. This allows the body full range of motion. One's kinesphere or reach space is defined as the area surrounding the body within the reach of the extremities:

> "The human body is completely oriented toward itself. It stands free in space. Its only resource . . .is its environment, the spatial sphere which surrounds it, and into which it can reach with its limbs." (Laban as cited in Maletic,1987,p.59).

Bartenieff further states:

> "Beyond the kinesphere the larger or general space can also be similarly perceived three-dimensionally. This perception of space outside our kinespheres alerts us to where we can transport our kinespheres."(p.25).

The use of one's kinesphere can also give indications as to one's ability to relate to others (Ramsden,1973). Limited use of kinesphere or intrusiveness into other's kinesphere without awareness is indicative of an individual's ability to define personal space, disrupting relationships and social interactions (Leventhal,1974).

Spatially and orientationally based metaphors are rooted in our physical and cultural experiences. Metaphors such as "down and out" or "on top of the world" have developed over time as a result in part to our bodies relationship and interaction with the environment (Tolaas,1991). Physical experiences within a spatial world with dimensional properties serve as a structure onto which later experiences are projected. Contents of figurative language have developed as a result of the dynamic interplay between affective, physical and spatial components. Metaphors are created as individuals develop over time within cultural units reflecting the physical and emotional experiences of the body as it functions in space (Becker,1993). The use of metaphor to explain the literal experiences of the body work well in therapy with this population as they provide tangible words and images for physical experiences of the homeless that do not have presently have names in this society.

Normal Development

In order to address issues of space, it is necessary to first understand the normal development of space usage. Discernment between internal and external space is necessary. At birth, infants do not differentiate between

internal and external stimuli (Spitz,1965). Empathic, non-intrusive holding can confirm a sense of goodness and security while non-empathetic caregivers leave feelings of emptiness and disorganization (Winnicott,1958). Attunement to the infant's needs on the part of the mother fosters the child's belief that the world coincides with his needs and the he has a capacity to create. Non-intrusive mothering promotes this illusion of self-sufficiency and becomes a permanent part of child's psyche and a basis for a cohesive sense of self (Kohut,1977). This provides the child with a sustaining sense of self-worth and a belief that he can care for himself throughout life. Intrusive, non-empathic caregiving would produce a child who does not have such a sense of self-worth or capability.

The feelings and emotions of a mother are transmitted through her touch to the infant. Primary caregiving serves to shape the infant's perceptions of the world and to structure internal vs.external reality through physical touch such as holding. The quality of this interaction is crucial. The mother's arms reinforce body boundaries while providing a safe haven in an otherwise hostile environment. The securing touch of the mother can counteract the ego dissolution produced by distress by restoring a sense of intactness. Mirroring on the part of the mother serves to

provide a accurate reflection of the child's affective states. If she is unable to do so, the child will not be able to develop a reliable sense of self (Stern,1985). The internalization of tactile, visual, and affective image of the mother provides a core for inner organization. Coherent organization of feelings, visual and physical stimuli develops three dimensional consistency and the ability to organize reality (Avstreih,1981).

Mahler (1975) describes the symbiotic relationship that develops between the child and the caregiver. In this phase, the infant begins to realize that his needs are met by a source outside his own body but has no understanding of what that source could be. He cathected to this outer body source in order to have his needs met. As this stage progresses, he begins to distinguish between internal stimuli (enteroceptic) and external stimuli (proprioceptic) from the surface of his body. The child then becomes aware of there being a boundary to his body but cannot fully comprehend this. Through straightening, he pulls away from the caregiver's body and begins to explore his own separateness. This is the beginning of his awareness of his own body as separate from others in the world. This is the basis for the development of the body image/ego. When an infant attempts to differentiate himself from his mother, he pushes away

from her and extends himself into space. By creating a greater space between them, the child becomes more clearly aware of his own body boundaries. Maturational activities such as crawling and walking are spatial verifications of separateness. Support on the part of the parent allays separation anxiety and allows the child to explore and practice being an individual.

At approximately 15 months, rapproachement begins. In this phase the child must negotiate the need to be near the mother as well as assert his autonomy. In rapproachment, a child is surrounded by space that functions to separate as well as connect him to his mother. They are no longer a single unit but autonomous, competent beings. The space between them now serves to create an arena for interpersonal interaction with the capacity to separate and engage by volition. The space around them does not belong to them but does not belong to another either. This is potential space for a relationship which Winnicott (1971) labeled "transitional space".

According to psychoanalytic theory as applied to movement development, space is first experienced through body openings in the oral, anal, urethral and phallic stages. Using Laban's effort/shape theory, Kestenberg (1975) focuses on the psychological ramifications of physiological

and motoric development. Mastery of efforts and planes serves developmental tasks. The neonate masters flow in the passive horizontal plane which aids in the tasks of attunement and integration of feelings and control. Communication and attachment is developed as the child is able to use the space effort in the horizontal plane. By being able to use direct space, a child can begin to meet his own needs while the ability to use indirectness in space is essential to be aware of the entire environment and perceive any threat present. Separation and individuation come with the use of weight in the vertical plane. Gender identification, decision making and remembering develop as a child uses the sagittal plane to explore time.

Shaping of space in directions (linear vectors) is genetically related to shape-flow-- the growing and shrinking of body shape (Kestenberg,1975; Kestenberg and Sossin,1979; Dell, 1977). Space is divided by lines which forms or relinquishes connections to objects. In their simplest forms, these can be across and sideways in the horizontal plane, downward and upward in the vertical plane or backward and forward in the sagittal plane. Shaping of space in planes reflects more complex relationships. Concave/convex multi-dimensional shapes can be created to express attitudes toward real or imaginary objects:

Shaping is the aspect of movement form

> which allows the mover to accommodate to the plastic character of objects in space, to their volume, or contour, their three dimensionality, and consequently to mold space into plastic forms *himself*, whether in clay as the sculptor does, or in thin air, as the dancer, mime and storyteller do. In shaping, the active part of the body constantly adapts to the form of space, whether this be an already formed object, a person, or a form being created by the mover. Anatomically speaking, shaping requires the constant blending of the muscle group functions in many joints to allow the body's fullest adaptation."(Dell,1977,p.55).

Each plane is used differently to serve certain ego functions that play a role in our relationships. Enclosing and spreading in the horizontal plane is in the service of exploration. Objects may be held closely or given more space. Descending or ascending in the vertical plane is utilized in confrontation. One may look down upon or up in admiration. Retreating and advancing in the sagittal plane serves to anticipate other's attitudes. This allows for engagement or avoidance in encounters.

Specific work in the area range of dynamics and spatial elements seems to directly effect impulse control, ability to sequence, ability to abstract symbols and conceptualize, and to a certain extent form object relations (Leventhal,1974). At first, objects and self are undifferentiated. As the ego develops and differentiation occurs, objects and their internal representations become permanent:

> "The development of shaping from its immature to its mature forms goes hand in hand with the development of object constancy and self-constancy, both evolving from identifications and complementarity of objects and self-shapes".
> (Kestenberg and Sossin,1979,p.156)

Kestenberg (1975) holds that there is a "hierarchic ascendancy" in the ego's control over motility. Affined qualities of flow, effort and shaping are indicators of the "harmonious development of ego functions". She states:

> "As a result, feeling safe becomes associated with the expression of well being and cautiousness with uneasiness; defensiveness is balanced by regulating contact with objects; and coping with external reality is structured by appropriate interpersonal relations. A lack of coordination between these patterns express conflict. The origin of the complex processes is revealed in infancy not only in characteristic sets of maturing motion elements, but also in corresponding body attitudes."(pp.238-9).

This can be seen in the use of planes for ego defense such in the use of the vertical plane to create a wall of denial. The sagittal plane is useful in splitting while the horizontal plane can be utilized for repression. If one of these dimensions is not developed, the ability to use that ego defense is lost (Becker,1994).

Space and Society

The relationship between man and society is one in which man and his environment serve to mold one another (Hall,1969). The delineation of territory serves as the fundamental means of creating social order (Scheflen and Scheflen,1972). Space is subdivided into bounded quadrants relegated for work, play and living. Physical and intangible barriers such as walls, fences, laws and dirty looks serve to keep the outsiders out and the insiders in. Human behaviors maintain territory as trespassers cross with bowed heads and narrowed bodies while "civil inattention" serves to insulate individuals on crowded sidewalks.

Hall's(1969) concept of proxemics looks at man's use of space as a specialized elaboration of national culture. By dividing interpersonal space into four distinct zones, analysis of space usage in regards to action and relationship is possible. Intimate distance (0-18 inches) is used for love-making, comforting and protecting. The high degree of physical contact provides an increased awareness of the other person. Personal distance (18-48 inches) allows contact with increase in visual range. This range facilitates interaction without overwhelming the senses. Social distance (48 inches to 12 feet) limits the spatial parameters of interaction. People work side by side and move

about at parties at this distance It serves to insulate people from each other and allows them to work in the presence of others without appearing to be rude. Public distance (12 to 25 feet and beyond) is well beyond the circle of involvement. People are reduced to being part of the environment. Trespass by an outsider within this distance alerts individuals to threat. By literally defining space by measurements, standards of interactional space are established and can be used in creating healthy living and working environments. A problem with Hall's work is that it defines the American culture as upper middle class and white. Variations of the approximated distances need to be made for other groups that are part of the American culture.

Bartenieff (1980) states that spatial configurations define relationships between people and outline the territory of action-interaction. Spatial configurations determine the tone of the group and reflect the order of social behavior. A file would provide a set-up of minimal interaction with one leader and passive followers. A row of people, on the other hand, establishes an interrelation of equality, sharing of closeness, same focus or action, solidarity and mutual reinforcement. A circle serves to bring people together. It not only provides the side to side communality but creates a central space for shared focus and

the opportunity to face one another. This increases body, space and effort tensions which create synchrony among the members. Vis-a-vis encounters can be provocative as individuals seek to establish and regulate personal territory. Locomotion can serve to regulate interaction within reach space. As trust is developed, individuals are able to share reach space.

Inclusion (Bell,1984), being in or out of a societal unit such as a family and its various component relationships, is important. A sense of belonging and individual identity, membership in subsystems, commitment and loyalty, and personal boundaries and contact result from having experiences in the personal and collective kinesphere. Degrees of inclusion are demonstrated through the nonverbal dimensions of lateral motility, proxemics, shaping of the body and space in the horizontal plane, accommodating, blocking and bonding behaviors. Inclusion is necessary for a sense of belonging, the ability to separate and the knowledge that others are committed as a whole to individual growth and reinforcement. Without it, isolation and distancing results as an individual becomes "out of sync".

As the population increases, certain members of society drop out and lose status in the struggle for housing,

territory and advancement (Scheflen and Scheflen,1972). Social behaviors such as scapegoating of undesirables and riffraff serve to control and exclude them to institutional territory such as shelters and mental hospitals. Scapegoating includes the assignment of blame, either overtly or covertly, combined with a degree of individual self-accusation. Decreased performance level, disordered, half-hearted and unco-operative behavior combined with anger and frustration lead to scapegoating. Reductionstic attitudes such as equating deviant behavior as a personality characteristic and labeling with undesirable traits can serve to rationalize discrimination and maintain the acceptance of these behaviors.

Space and Homelessness

Housing, with adequate space and security, meets basic human needs (Baumann,1993). The term "home" is more complex implying order, identity, and connectedness. One can experience domestic comfort and well-being there. A home provides a haven and signifies having a place in the world.

The consequences of not having a "place" are difficult and dangerous. Exposure to violent situations, not having warm clothes, not being able to find a place to live, sleeping in the cold, and not having privacy are listed as

major stressors in the lives of homeless individuals (D'Ercole and Struening,1990). General deprivation and environmental conditions of public shelters may trigger flashbacks to earlier periods of victimization. Shelters are often located in dangerous neighborhoods exposing the women to rape, assault and random acts of violence. Poor quality of living and lack of control over one's environment diminish any feelings of self-efficacy. Homeless individuals often believe they are solely to blame for their homeless status and have no control to alter it. The homeless environment and many shelters offer no other alternatives and support such beliefs (Goodman, Saxe and Harvey,1991). Compounded by uncertainty and instability, homelessness distorts one's ability to organize and make sense of her world. The ability to control access to one's space and possessions is lost.

Homelessness itself is a depersonalizing and isolating condition, creating distrust and rupturing social bonds. Personal boundaries are lost as individuals must conduct all activities in a public sphere. Homelessness facilitates the break down between personal/private space and general/public space. Because, according to Kestenberg and Sossin (1979):

> "To localize distant objects, we reach within the confines of our personal space and point beyond our reach-space into the general space, thus making it our own. At the same time we use these directional movements

> for defenses against stimuli and objects by barring access to the body or by opening up boundaries for appeasement." (p.155).

When lines between personal and public space are blurred, a distinction cannot be made and the homeless become spatially defenseless. Research finds a relationship between long-term lack of privacy and mental health: "Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences." (Van der Kolk,1987,p.31).

Lack of privacy in personal matters alters normal behavior in an effort to cope with circumstances. Adaptations and disturbances related to mothering in the public eye include an intense desire to demonstrate internalized values as a way of asserting self, questioning the certainty of anything, the ambiguity of everything, conflict over the need for attention and the experienced demand for independence, the unraveling of the "mother" role and the experience of being externally controlled (Boxill and Beaty,1990). Without opportunities for private time or space, private life activities such as eating and bathing are now public life with permission.

Continual changes of residence contribute to instability of social context (Baumann,1993). One is unable to form a cohesive community identity and loses a part of

herself that comes from social recognition. Without consistent, predictible interation between self and the environment, it is nearly impossible for the homeless to experience in their lives progress to a higher level of functioning or even a regular routine. In fact, the reverse is true as they experience life as a downward spiral due to homelessness, decreasing sense of confidence and a tenuous reception by society.

In an effort to preserve a semblance of normal life, individuals struggle to maintain physical, social and symbolic boundaries. Lack of physical boundaries makes personal safety, possessions, and family members more vulnerable. Boundaries are needed for protection. As physical boundaries are often inadequate, social boundaries are constructed to keep individuals and family members distinct from other shelter residents. Symbolic boundaries serve to protect personal belief systems in the shelter's culturally diverse environment. Fatigue and despair are caused by being on the streets during the day with no place to safely rest or let down one's defenses. Loss of connection and feelings of self-respect are closely tied-in to residential identity. Many women feel that they are discriminated against and degraded by service agencies because of their lack of housing. Deficiencies in

self-determination, privacy and stability serve to undermine efforts to escape the cycle. Lack of boundaries, intimacy, privacy and adequate rest demonstrate the essential role housing plays in maintaining personal integrity, health and economy.

PART 3. DANCE/MOVEMENT THERAPY

Dance/movement therapy is defined by the American Dance Therapy Association (ADTA) as "The psychotherapeutic use of movement as a process which furthers the emotional and physical integration of the individual." As a verbal therapist would use words, a dance/movement therapist elicits movement as her primary means of therapeutic interaction. Schmais (1974) postulates three major assumptions concerning dance/movement therapy practice: (1) Movement reflects personality. (2) The relationship established between the therapist and the patient through movement supports and enables behavioral change. (3)Significant changes occur on the movement level that can affect total functioning.

The assumption that the mind and body are interrelated is the basis for the use of dance/movement therapy to effect changes in feelings, cognition, physical functioning and behavior through movement. Visible movement behavior is analogous to intrapsychic dynamics as the body comprises the whole of an individual's life experiences (Schmais,1974).

Attributes from the art of dance such as breath, rhythm and dynamics are structured by the elements of tempo, lines

and shape and provide an outlet for emotive expression. Replication and synchrony serve as the basis for the development of an empathetic relationship as client and therapist move in harmony. Onto such a relationship, the client is able to project past experiences with an opportunity to recreate and re-experience them. Such projection is termed transference and is necessary for therapeutic relationship. By focusing on emerging movement behavior, the therapist is able to assess an individual's emotional and cognitive states and provide therapeutic interventions.

The Experience of the Body

Dance/movement therapy seeks to tap the vital resource of the body in order to access its "living experiences." Because a person lives with, in, and through the body, the total being is affected by the bodily experiences of life. As the body continually reacts to the environment and constantly registers emotional experiences in patterns of motor behavior, individuals are often unaware of the significance of these kinaesthetic experiences (Rossberg-Gempton and Poole,1992). Dance/movement therapy is an ideal opportunity for people to gain a kinesthetic

awareness, and maintain a sense of control over movement patterns and the accompanying feelings.

Healthy functioning implies adaptive behavior on the part of the individual. When an individual is impaired in his ability to adapt to his environment, his options for how he can respond to his situation are equally limited. This can be seen in exaggerated or diminished use of effort and/or space, inappropriate combinations of dynamic elements or use of body parts. Dance/movement therapy seeks to rectify discrepancies on a movement level and integrate surfacing ego strengths:

> "The act of moving together literally mobilizes people. The energy released tends to reduce fragmentation, to diminish defenses and to permit the integration of feelings, thoughts and actions."
> (Schmais,1974,p.11)

Change can lead to insight, personal and interpersonal growth with respect to appropriate actions and interactions. Expression of feelings and sharing can prevent withdrawal into isolation, foster growth and extension of self. Integration enhances body image and develops of a sense of identity:

> "The experience of building one's own organic structures in space can subtly build confidence in one's self. To do this with others helps to develop a sense of supportiveness from the community and an ability to make adaptation for the interdependence of that support."
> (Bartenieff and Lewis, 1980, pp.144-5)

Dance therapy, in making use of the most basic form of communication, offers an individual a means of relating to the environment or to other people when he is otherwise unable to communicate by the patterns of his illness (Chace,1993).

Observation skills are crucial to the work of the dance/movement therapist as she facilitates treatment. Observations can be used to assess and identify various clinical needs. Postural/gestural movements, incongruences, held areas or symbolic gestures can be indicative of mental illness, trauma or other psychodynamic issues being manifested on a body level. This aided in the identification of problems that could be addressed in the group.

Related Work and Research

Due to the paucity of literature and research on dance/movement therapy with the homeless, it is necessary to refer to relevant work done with other populations. Clinical and experimental work with child sexual abuse victims, domestic violence and substance abusers all yield applicable therapeutic methods and material.

Childhood Sexual Abuse. In work with victims of childhood sexual abuse, Weltman (1986) and Goodill (1987) discuss working with the traumatized body. In sexual abuse,

the physical body and personal space are forcibly invaded resulting in a feeling of powerlessness, betrayal by others and by self as the body responds to the sexual stimulation. As the abuse occurs on a nonverbal, physical level, the body is the site and receptacle of trauma. The nonverbal aspect of dance/movement therapy can amplify feelings and clarify thoughts making verbalization possible. Through a nonverbal exchange, the survivor is able to communicate experiences for which there are no words. Dance/movement therapy facilitates integration of experiences, increases awareness of inner feelings and sensations and stimulates kinesthetic sense. This can provide access to less explored motor memory traces, ease discrepancies between feeling and thought and integrate the unacceptable parts of the self. Goodill discusses working with an individual's kinesphere and defining one's personal space to counteract the destructive effects of the abuse. By exercising control over their space, a survivor can regain a sense of control and ownership over their own bodies. Games structuring appropriate interactions, proximity and touch can establish healthy boundaries, communication and a sense of safety.

Domestic Violence. Bartky (1980), Leventhal and Chang (1991) and Scarth (1992) have provided both clinical and experimental research in domestic violence. As in sexual

abuse, the trauma is experienced on a physical level. Dissociation and distortion of reality can result. Research indicated restricted use of space, minimal movements and over-controlled body action due to limited coping styles characteristic of battered women (Bartky,1980). Alteration of external actions along with modifications of internal perceptions produce change. Dance/movement therapy addresses patterns of helplessness, ambivalence, and inactivity by internalizing a positive self-concept and regaining physical and emotional control. Through dance/movement, victims are able to embody independent actions and experience the conscious choice to move.

Substance Abuse. Dance/movement therapy offers a unique approach to working with substance abuser's characteristic resistance, denial, isolation, and low self-esteem (Milliken,1990). The non-verbal, body-oriented approach addresses the substance abuser's lack of body awareness, identifying the underlying issues, and allowing for the safe expression of affect. Dance/movement therapy works with the body on the same level as the addiction and can be a vehicle to establish a new and different relationship with their bodies (Perlmutter,1991). Some substance abusers have refined verbal skills which they use to avoid responsibility for their own behaviors. The nonverbal directness of

dance/movement therapy bypasses such avoidance and, at the same time, provides reality testing during the formation of new coping behaviors (Fisher,1990).

Reiland (1990) discusses field dependency among alcoholic women. Field-dependency refers to the infant symbiotic state in which the child cannot distinguish between self and other and experiences the world without clear definition of boundaries. Inability to articulate oneself from the environment produces poor organization, control, utilization of one's body efficiently and reaction to the environment. It decreases an individual's ability to overcome addiction. Dance/movement therapy can promote field independence through facilitating separation and individuation and developing a greater sense of body boundary.

Francisco's (1994) research showed a significant gender difference in adult substance abusers. Women demonstrated an increased loss of self-esteem, negativity and reliance on external reinforcement. This was manifested on a body level by narrow limb articulation, predominate use of near reach space and a vertical body attitude which diminished their capacity to cope with the environment and assert individual needs and wants.

Childhood sexual abuse, domestic violence and substance abuse are all factors that are applicable to the population of homeless women. These are issues that dance/movement therapy through the body level experiences is particularly well-suited to address.

CHAPTER III. OUTLINE OF DANCE/MOVEMENT THERAPY WITH HOMELESS WOMEN IN CLINICAL PRACTICE

In order to draw together the many ideas presented in the preceding review of literature on women and homelessness, space and dance/movement therapy, a description of the author's clinical experience with this population will follow. This chapter will provide a clear picture of how dance/movement therapy can be used to increase awareness of personal, interpersonal and social space for women living in a homeless shelter.

Dance/movement therapy was first introduced at this shelter in 1993 by a dance/movement therapy student from Hahnemann in collaboration with a social work student from Temple who served as a verbal co-therapist. Based on this initial program, this therapist took over the following year without the aid of a co-therapist.

Women were chosen by a staff member to form two groups that would meet every Tuesday for eight weeks. There were three such eight week groups throughout the year. Women who were not drug and alcohol rehabilitation but had a history of either domestic or sexual abuse attended the 10:00-11:30 am group while women who were in recovery from drug and

alcohol abuse attended the 1:30-3:00 pm group. The recovering addicts may have also been victims of domestic or sexual abuse.

Initial goals included body awareness and mobilization, appropriate and alternative expression of anger and other emotions, increase energy with a decrease of tension, and developing a sense of identity, social awareness and group cohesion. Very early in the program, issues concerning personal space and privacy began to emerge. This particular shelter houses women dormitory style with two person cubicles formed by screens. The cubicles, shower and toilet stalls have no doors. Over half of the sixty long-term residents must pass through other residents' cubicles in order to reach their own. These quarters were subject to revocation as punishment for non-compliance to shelter rules including missing groups. "Consequences" could entail an early curfew, clean-up duty or one to three nights sleeping in the large general room known as "spill-over" in which the movement group was held.

The lack of personal boundaries in the shelter in addition to the already compromised boundaries of the women suffering from abuse or substance addiction seemed to be a common problem among the otherwise diversified population. Some women attempted to create boundaries through isolation

and rigid definitions of personal space. Others would decrease their interpersonal space in interactions to create a more enclosed space. Focus on space that progressed from internal/external awareness through to societal space was implemented into the eight week groups. Such a superstructure added direction and purpose to the otherwise inconsistent membership of the group. Conflicts between outpatient services, job training classes and doctor/lawyer appointments during scheduled hours as well as women moving out made group attendance uncertain from week to week. The staff was busy and overworked which lead to inconsistency in assignment of new group members. This caused a lack of continuity between groups ending and new groups beginning.

Description of Group with Clinical Examples

Groups began with a verbal check-in and recapitulation of any events that had transpired over the previous week. As circumstances in a homeless situation can dramatically change in a short period of time, it was important to acknowledge the impact of such events in each woman's life. Notification that housing is or is not being granted, setbacks in recovery or court decisions are outcome shaping occurrences. This initial time allowed the group to share in

the woman's excitement or disappointment which laid the foundation for group empathy and cohesion.

Following check-in, a warm-up with music served to focus the women on their bodily sensations. Particular care was taken to notice any sore or held spots. Self-massage and breathing exercises were used for relaxation, body awareness and self-nurturance. As much as possible, affect was connected to physical sensation especially in the case of the drug and alcohol rehabilitation. Many recovering addicts are accustomed to masking emotions and sensations through substance abuse. Reconnecting the emotion with the correlating physical response is essential to the women to achieve optimal functioning. It begins to help the women discriminate between internal and external space as they emotionally and cognitively react to events in their environment.

Case 1-- Client A., mother of six children of which all are in foster care due to A.'s substance abuse, reported feeling a hard sinking feeling in her chest when she became angry with another resident. When asked to describe her response to this physical sensation, A. stated that it was an uncomfortable feeling, one that would cause her to use drugs in order to escape feeling it. Now, A. related that she let

herself indulge in the feeling, analyzed it and enjoyed her new sense of control over it. Her ability to identify her physiological response in conjunction with her old emotional response helped concretize for A. the changes in her behavioral patterns and appreciate a new found sense of power.

Following the warm-up, the group would begin moving. Depending on the energy level of the group, this could be free style dancing or a structured movement task. As many of the women have a diminished use of efforts and space, activities structured to increase movement repertoire are desirable. Free style dancing that incorporates mirroring can increase group awareness to movement styles. Taking turns leading and mirroring movements can initiate movement exploration outside of an individual's usual preferences. A game of "detective" in which one person must guess who is leading the group's movements demands observations skills on a physical level and utilizes past group movement experiences.

While free style movement can get a group moving, it can also be used as a defense against self exploration or connecting to the group if the mover is unwilling to take on another's moving style. In such cases, structured movement

activities provide clear boundaries. Increasing an individual's awareness of her kinesphere is ideal for strengthening defenses while encouraging movement exploration. Visualization through imagery can aid this when mental functioning is otherwise limited to immediate goals and needs. The consistent use of an image can show progression over time.

Case 2-- C., a victim of childhood sexual abuse and pregnancy, adult drug abuse and prostitution, had many difficulties maintaining personal boundaries. Being extremely overweight, she was self-conscious about her body and flashbacks were beginning to evoke memories of her abuse. Blackouts left her unconscious on the floor and she voiced concern of not feeling safe in the shelter environment. The lack of privacy plus surfacing memories were diminishing her ability to test reality. In 1:1 dance/movement therapy sessions, C.'s worked with exploring her kinesphere as her own personal space that she always had with her. Initially, she described it as being covered in metal siding like a battleship with no portholes. The following week, she now described it as being boarded up with wood planks with a trap door on the side. Using such images, this therapist and C. discussed issues of isolation

and withdrawal, giving permission to approach and share space and feeling secure. Gradually, C. described her kinesphere as opaque with her being able to see out and others being able to see inside a little bit. As she became more comfortable and clear with the concept of having a personal boundary, C. was able to engage in duets without engulfing or distancing her partner. The shelter was not equipped to provide the privacy and personal space C. needed for her own mental health. The dance/movement therapy concept of personal kinesphere offered C. a skill to make space a tangible commodity for herself when her environment could not offer her such a respite.

Props serve an important role in materializing space. A ball can serve to form a web of connection between otherwise disconnected group members. Spatial intention, focus and spontaneity can serve to get all group members involved and active in a shared process. A stretch cloth can be used to define interactive space between two or more people. The circle, however, can be seen as the most important "prop" of all: "The circle formation permits equal sharing, visual contact among group members and a sense of security in a clearly defined space" (Chaiklin and Schmais, 1979, p.23). Communal space evolves as individual boundaries lose

clarity. The circle can grow or contract to meet the needs of group members who may choose to be inside it, out of it or part of it. From it, other forms of relating can develop. The circle can create the sense of security needed for a group to begin to relate. This therapist identifies the space created by the group as unique, created by this specific configuration of individuals who each add to it. By pointing out the significance of each group member to the circle, a sense oneself as an integral part of a community can begin to develop.

Case 3-- One morning group comprising abused women was unusually small but closely knit. On this day, only three of the regular four were in attendance. The fourth, C., was in a psychiatric ward. Her gradual break-down over the past four weeks had great effect on the life of this group. This day, the group was silent. The therapist brought out a stretch cloth and handed it to each member. What began as a gentle tugging became a more aggressive pull on the stretch cloth. Angry feelings about living in the shelter began to be verbalized. At the encouragement of the therapist, the group came inside the stretch cloth. Each member took turns leaning back into the stretch cloth while being supported by the other group members. This gradually became less

structured as the group began to move inside the stretch cloth in unison, each leaning back when she needed support. Feelings of being safe, nurtured and part of the group were expressed. A disproportionate number of the group was in one end of the cloth. When questioned about the open area at the other end of the cloth, the group agreed that was "C.'s place." C.'s contribution and subsequent absence did not go unacknowledged by the group. Each were able to discuss the personal impact she had on each of them and their own personal fears of mental illness. The physical manifestation of her presence/absence concretized the group's relationship to her.

As a group evolves, each takes on its own personality and life. Re-creation of their current situations through the use of metaphor provided vital material with which to work. The room, other group members and props took on greater significance as themes developed over the weeks. Memories of childhood were a common theme as the groups sought to resolve both early and current conflicts.

Case 4-- One particular group would repeatedly ask to play childhood games such as jump rope and hide and seek. On this day, a game of musical chairs was started. As the game progressed from twelve people to two, it was obvious that

the game had taken on a greater meaning. One woman, in particular, was intent on winning the game. A. was both a battered wife and recovering alcoholic with two children in foster care. (She had been at the shelter for over eight months and was still waiting to hear about housing. The other woman, S., had moved out of the shelter into an apartment the previous week and had returned to finish the eight week group.) In the end, S. won and A. became furious, stomping and kicking. She yelled at S., stating S. had her own place and she did not need the chair. A. went on to say that she had been waiting a long time for her own "place" and now S. had stolen it out from under her. This therapist then asked each group member what the chair represented to her. Ideas such as power, belonging and acceptance were named. Each group member was then given the opportunity to sit in the lone chair and share her experience. In a group setting, simple objects can become powerful metaphors for issues with which the group is dealing. A.'s resentment was not necessarily directed toward S. as much as it was toward her situation. Dance/movement therapy provided means for her need for space to become material. As A. was now able to see that having a place meant many different things, she was able to address her underlying issues of low self-esteem and feeling of being an outsider to both herself and her family.

In all therapeutic relationships, closure is a healthy and necessary process. With the fluctuation of group membership and instability of residential status, it was especially important to have definitive closure at the end of each group. Many of the women have separation and abandonment issues that make closure difficult. Each group would end by everyone standing in a small circle. Verbal recapitulation of the group's events and process, feelings and applications to daily life were expressed. The number of sessions left in the series was always made clear, as well as an encouragement to each woman to think what she would like to get out of the group in the remaining time. Certificates of completion were presented at the last group. It was consistently the most poorly attended session.

Countertransference

As crucial as the therapeutic transference is, there are many difficulties that can arise for the therapist such as overidentification or overinvolvement. It is important for the therapist to be aware of her own issues and how they affect the therapeutic relationship. Many people come to this field with rescue fantasies, personal needs and agendas (Stanton-Jones,1992). These do not serve the needs of the clients.

Dance/movement therapists are especially sensitive to countertransference reactions on a body level. Attunement to these are helpful in understanding the patient's ego state and what would be effective treatment:

> If the therapist is able to withstand and contain the patient's projected impulses and feelings, the latter is then able to address their content therapeutically.
> (Dosamantes-Alperson,1987,p.210)

To be able to utilize the countertransference response, one must always be conscious of them. Their comprehensiveness allows objectivity in managing them. Inexperienced therapists may try to block the emergence of negative countertranference, resist setting limits or boundaries, inhibit or act out impulses or avoid cognitive correlations to affective reactions (Dosamantes-Alperson1987). Examples of poor maintenance of one's countertransference are given in Leventhal and Chang's (1991) article on work with battered women. Identification with the "victim" can lead to blurred boundaries and involvement in power struggles can re-enact abusive relationships.

As a white therapist working with a predominantly Afro-american population, issues around racial/cultural differences were inevitable. As the two populations use space differently, perceptions of the other as threatening, aloof or invasive were addressed. Efforts are made to find

similarities between the two as well. In one example, a black woman and I were partners and had to work together in a game. At one point, she turned to me and said, "I never thought I would be giggling with a white girl like we were friends." Other instances were not as positive as hostility or fear caused clashing. This therapist made every effort to be as clear as possible and resolve such feelings openly with the clients. Respect for differences in lifestyle choices and an effort to learn cultural symbols and associations aided in the facilitation of a therapeutic working relationship.

Transference/countertransference with a male therapist was another issue raised. Whereas many of the women have had poor relationships with men, a male therapist in this setting would have to be able to handle transference ranging from hostility to fear to idealization. A male therapist able to contain and structure such projections could serve as a positive model for future interactions with men.

CHAPTER IV. DISCUSSION

The initial hypothesis of this thesis asserts that homelessness is a state of compromised space leading to deficits in personal and interpersonal boundaries and that dance/movement therapy can play a beneficial part in re-establishing these boundaries. Therefore, based on the literature review and the author's clinical experience this discussion will focus on the relationship between space, the treatment issues of homeless women and dance/movement therapy's role in this treatment.

Everyone has basic needs that must be met. Maslow (1954), in looking at self-generated motivation, theoretically developed a hierarchy of needs. The first four are physiological needs, safety needs, need for a sense of belonging and love, and need for esteem. These are termed "deficit" needs as man is only motivated to fulfill them in their absence. When these needs are met, the individual can begin to address the fifth need, the only need in Maslow's hierarchy that is not a "deficit" need.

The fifth, the need for self actualization, fundamentally differs from the first four. Self-actualization comes from activities done simply for satisfaction and personal growth. It is the only need listed that is continually motivating. Yet, if the first four are not met, the individual is unable to integrate his interests, talents, and abilities which is necessary to achieve self-actualization.

When homelessness is characterized by a struggle just to meet basic needs, it is difficult to see a way through to a better existence. Each day, the simple truths of homelessness rob individuals of basic physiological and safety needs and deteriorate their sense of self-esteem, belongingness and love. When such "vision" is limited, discouragement leads to limited use of the body and space. When the body is immobile, there is decreased exposure to opportunities that could change one's living situation. Similarly, spatial tension is formed by attraction between an individual and an object in the environment (Bartenieff,1980). Loss of clarity in spatial intent can result when an individual loses his own purpose and submits to another's idea of him. Homelessness destroys the skills that allow individuals to differentiate the levels of space. When boundaries are blurred, it is difficult for the

individual to apply the skills required to meet the four basic needs. Opportunity to grow and develop through self-actualization is a distant, often unrecognized, goal.

Ginzberg (1991) provides the sole article on dance/movement therapy and the homeless. She found that homeless men moved from an isolated and passive stance to a more erect, active and expansive one in response to a simple greeting. It appears that an acknowledgement of their very existence could germinate a sense of beingness and identity. This is not unexpected in a society that views homelessness as a failure, whether on the individual's or its own part, and chooses to respond by ignoring it.

The urban nature of homelessness is typified by the inner city shelter in its negativity, isolation, distrust, anger, filth, violence, helplessness, and lack of safety i.e. a sense of total vulnerability. Ginzberg believes that dance/movement therapy could transform negative, debilitating and paralyzing influences by revitalizing and mobilizing the residents. The establishment of trust, reduction of tension, enhancement of self-esteem, facilitation of self-expression and creativity as well as group interaction, communication and understanding by moving together could make this transformation.

Attention to space is a key element in achieving these goals. Many are homeless due to ruptured personal, interpersonal and societal boundaries. Shelters that do not provide an environment that establishes healthy boundaries are failing to assisting people in developing the skills necessary to escape the cycle of homelessness permanently. When issues of space are addressed, homeless women are able to make greater progress. This may infer that boundaries and space are vital when trying to reach a state in which the fifth need, self-actualization can be addressed. At the very least, space is a component of the first four needs. Referring back to Maslow, the four basic needs can be addressed in terms of boundaries. Physiological and safety needs can be met by adequate shelter in which privacy is a component. Esteem and belongingness come from healthy social inclusion in which an individual can have his emotional needs met without personal risk.

An example of the progress that can be made when the spatial component of homelessness is addressed is a program termed Sistering in Toronto, Canada (Breton,1984). Located within a local community center, the homeless women are not isolated from the community. A nurturing environment provides refuge, privacy, social contact, task instrumentality, pleasure and personal growth. Furniture

arrangement provides an individual with an opportunity to choose the desired level of interaction. A positive physical environment plus realistic expectations of the women can provide the support necessary to overcome homelessness.

When such facilities are not available, dance/movement therapy's understanding of space and its utilization can provide basic skills and awareness for the women. Through increased awareness of internal feelings, the women can begin to feel that their bodies are their own and not only the site of abuse. Developing a comfort level with one's body through movement increases one's sense of identity and wholeness. As a strong sense of self forms, an individual is less dependent on the environment to fulfill her needs for love and acceptance.

As all needs cannot be met from within, it is necessary for a person to learn healthy means of interacting. As dance/movement therapy meets a client at her level, it allows for the recapitulation of any relationship the client needs to resolve. Through movement activities, role plays and mirroring, a person can learn from her own experiences as they are manifested in her body. The experience of being a group member, choosing how and when to move with others further solidifies the growing sense of self-worth and efficacy in the women.

Dance/movement therapy has been found to support change as the treatment becomes a psychological home for the women. The establishment of a safe environment through confidentiality and support is developed as the group coalesces and forms its own boundaries. Consistency of time and length of meeting provides further structure and support.

The literature suggests that scale development on movement parameters of this population similar to Bartky's (1980) study on battered women and Francisco's (1994) study of adult substance abusers would yield fruitful results. Such work could provide needed basis for an outcome study that would include pre- and post-testing of movement parameters (intrusiveness, near reach space, etc.) of a control and experimental groups. A questionnaire focusing on the individual's perceptions of space (i.e. I am aware of internal responses to external events; I can tell people that I need more space) would also be administered prior and after the eight week sessions.

CHAPTER V. SUMMARY

A review of the literature indicates that homeless women frequently suffer loss of personal, interpersonal and societal space. These losses appear to effect the individual's capacity to overcome her current situation.

Often, previous experiences in which personal boundaries were violated either by self or others lead to deterioration of the individual's sense of capability.

In order to escape the cycle of homelessness, it appears that an individual must restore healthy boundaries to herself and to her environment in order to have the skills to stabilize her life. Nonverbal, bodily experiences integrated with verbal labeling can solidify boundaries.

Literature supports that homelessness and factors leading to homelessness are traumatic experiences to both the body and the mind.

The literature reveals that ruptures in personal, interpersonal and societal space can be addressed by dance/ movement therapy and spatial theory.

The clinical work described herein suggests that dance/ movement therapy can be a useful and positive addition to a shelter's program and should be continued and expanded to meet the needs of those at other shelters for the homeless.

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